Employer Authorization Form

Please provide the employee with the following services: (Please check all that apply)

Drug and/or alcohol testing (Please check type and reason below)

PLEASE SELECT EITHER OPTION 1 OR OPTION 2

OPTION 1: Using Noblesville Urgent Care lab and MRO

☐ DOT Urine Drug Screen (5 panel)

Please check one: ☐ FMCSA ☐ FAA ☐ FRA
☐ FTA ☐ PHMSA ☐ USCG

☐ Non-DOT Urine Drug Screen
- ☐ 5-Panel Standard Urine Drug Screen
- ☐ 10-Panel Standard Urine Drug Screen

☐ Oral Fluids Drug Screen
- ☐ 5-Panel Oral Fluids
- ☐ 9-Panel Oral Fluids
- ☐ Oral Fluids Alcohol

☐ Hair Drug Screen
- ☐ 5-Panel
- ☐ 5-Panel w/exp. Opiates
- ☐ 7-Panel
- ☐ 9-Panel
- ☐ 12-Panel

OR

OPTION 2: Using your company paperwork, lab, and MRO

Collection Only

Urine Drug Screen:
- ☐ DOT
- ☐ Non-DOT

CCF:
- ☐ On file at center
- ☐ Donor will arrive with

Oral Fluids Drug Screen:
- ☐ 5-Panel
- ☐ 9-Panel
- ☐ Oral Fluids Alcohol

Hair Drug Screen:
- ☐ 5-Panel
- ☐ 5-Panel w/exp. Opiates
- ☐ 7-Panel
- ☐ 9-Panel
- ☐ 12-Panel

Reason for drug/alcohol testing:

PHOTO ID IS REQUIRED!

☐ Pre-placement ☐ Post-Accident ☐ Reasonable Suspicion
☐ Random ☐ Return-to-Duty
☐ Follow-up ☐ Observed Collection

Employer Authorization Form

Employee name:________________________________DOB:____________________SS#:______________________

Employee address:______________________________City:________________State:______Zip:_____________

Employee phone #:__________________________Scheduled date(s):________________Time: _____________

Company name: ____

Company address:______________________________City:________________State:______Zip: _____________

Treatment authorized by: ____
Name and title *(please print)*

Signature:____Phone: _____________________________________

Employer information

DER/Company contact for results and/or physician call: ____

Preferred communication *(please check all that apply)* ☐ phone ☐ fax (secure) ☐ e-mail ☐ mail

Address:____City:________________State:______Zip: _____________

E-mail:____

Phone:______________________Ext.__________Secure fax: ____________________________________

Billing address *(only if different than above)*:

Address:____City:________________State: Zip: _____________

Phone:______________________Ext.__________Fax: ____

If billing to carrier – Policy #:______________Effective dates of policy:______________to ______________

Company or WC insurance carrier: ____

Claim #: ____

Adjuster name: ____

Adjuster phone: ____

☐ Injury/Accident Date of injury:__________Injured body part: ____________________________________